2009 DRAFTING REQUEST

Bill

Received: **06/25/2009**

Received By: **rryan**

Wanted: **As time permits**

Identical to LRB:

For: **Jim Sullivan (608) 266-2512**

By/Representing: **Nicole Hudzinski**

This file may be shown to any legislator: **NO**

Drafter: **rryan**

May Contact:

Addl. Drafters: **pkahler**

Subject: **Health - miscellaneous**
Insurance - health

Extra Copies: **TJD**

Submit via email: **YES**

Requester's email: **Sen.Sullivan@legis.wisconsin.gov**

Carbon copy (CC:) to:

Pre Topic:

No specific pre topic given

Topic:

Disclosure of charge information

Instructions:

See attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	pkahler 06/25/2009			_____ _____			
/P1	rryan 11/03/2009		phenry 06/25/2009	_____ _____	sbasford 06/25/2009		State
/1	pkahler 11/03/2009	csicilia 11/03/2009	jfrantze 11/03/2009	_____ _____	mbarman 11/03/2009	sbasford 12/01/2009	

FE Sent For:

<END>

at intro

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FE Sent For:

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Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	pkahler 06/25/2009	1 ijs 11/3 09					
/P1			phenry 06/25/2009		sbasford 06/25/2009		

FE Sent For:

<END>

P1

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Bill

Received: **06/25/2009**

Received By: **rryan**

Wanted: **As time permits**

Identical to LRB:

For: **Jim Sullivan (608) 266-2512**

By/Representing: **Nicole Hudzinski**

This file may be shown to any legislator: **NO**

Drafter: **pkahler**

May Contact:

Addl. Drafters:

Subject: **Health - miscellaneous**
Insurance - health

Extra Copies: **TJD**

Submit via email: **YES**

Requester's email: **Sen.Sullivan@legis.wisconsin.gov**

Carbon copy (CC:) to:

Pre Topic:

No specific pre topic given

Topic:

Disclosure of charge information

Instructions:

See attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	pkahler						

FE Sent For:

<END>

2009 DRAFTING REQUEST

Bill

Received: **09/16/2008**

Received By: **rryan**

Wanted: **As time permits**

Identical to LRB:

For: **Jim Sullivan (608) 266-2512**

By/Representing: **James Kiser**

This file may be shown to any legislator: **NO**

Drafter: ~~tdodge~~ rryan

May Contact:

Addl. Drafters: **pkahler**

Subject: **Health - miscellaneous**
Insurance - health

Extra Copies:

Submit via email: **YES**

Requester's email: **Sen.Sullivan@legis.wisconsin.gov**

Carbon copy (CC:) to:

Cancel this

New number -3042

Pre Topic:

No specific pre topic given

Topic:

Disclosure of health care cost information.

Instructions:

See attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	tdodge	/P1 ajs 9/23/09					

FE Sent For:

<END>

Redraft of 07SB337 (LRB-3210/1)

Note there was a SSA offered by Sullivan

Question: Does Sullivan want to use Original or SSA for redraft

Amend uses "median billed charge" instead of "usual & customary"
Amend uses 25 services instead of 50

9/25/08 Sullivan 6-2512 - talked to Matt

Put on hold for now

Dodge, Tamara

From: Hudzinski, Nicole
Sent: Wednesday, April 15, 2009 12:39 PM
To: Dodge, Tamara
Subject: RE: LRB 0268

~~We were hoping to have the~~ [redacted] drafted. We would like to have it ready to circulate right away if it is removed from the budget. Please redraft.

Also, I do need 0271 drafted. This one is more of a priority please.

Thanks,
nicole

From: Dodge, Tamara
Sent: Wednesday, April 15, 2009 12:36 PM
To: Hudzinski, Nicole
Subject: RE: LRB 0268

Nicole,

This draft was not completed. I was told by someone in your office to hold on this draft until further notice. (The same was true of LRB-0271 regarding disclosure of health care cost information.)

If you would me to complete either draft, please let me know. The cancer researcher draft is in the budget bill with a few changes from last session's draft.

-Tami

Tamara J. Dodge
Attorney
Wisconsin Legislative Reference Bureau
P.O. Box 2037
Madison, WI 53701-2037
(608) 267 - 7380
tamara.dodge@legis.wisconsin.gov

From: Hudzinski, Nicole
Sent: Wednesday, April 15, 2009 12:30 PM
To: Dodge, Tamara
Subject: LRB 0268

Tamara, can you please send me an electronic copy of LRB 0268, relating to access to cancer information by researchers.

Thanks,
Nicole Hudzinski
Office of Senator Sullivan

Ryan, Robin

From: Hudzinski, Nicole
Sent: Wednesday, April 15, 2009 3:02 PM
To: Ryan, Robin
Subject: RE: Redraft of 07 SB 337

The sub please.

From: Ryan, Robin
Sent: Wednesday, April 15, 2009 3:00 PM
To: Hudzinski, Nicole
Subject: Redraft of 07 SB 337

Nicole, Do you want a redraft of SB 337 or the substitute amendment?

Robin

Ryan, Robin

From: Ryan, Robin
Sent: Wednesday, April 22, 2009 12:44 PM
To: Hudzinski, Nicole
Subject: Redraft of SB 337

Hi Nicole,
I unexpectedly have to leave for the day. My question on the redraft of the sub to SB 337 concerns the language in proposed 146.903 (2) (b) 1.
What is it that you want DHS to do? As I understand it they have to pick some number of presenting conditions, and then identity 25 services, tests, or procedures that are relevant to treating the condition. How many conditions are they supposed to pick? The bill says the are to to pick these conditions based on MA claims data, but doesn't provide any further direction on how to pick. Can you provide any further specificity?.

Thanks
Robin Ryan

5/8/09

Call from Nicole

DHS annually identifies 25 most common presenting conditions
- does this by reviewing MA claims data.

Each doc. prepares document that includes cost of dealing with each of the 25 presenting conditions and for each of the conditions shows cost by:
- median billed
- MA reimbursement
- M'Care reimbursement
- 3rd party

Not specifying the services that are involved in treatment so recognize won't be apples to apples comparison

2007 – 2008 LEGISLATURE

LRB-0205/2
RLR:cjs&PJK:cjs:rs

SENATE SUBSTITUTE AMENDMENT 1,

TO 2007 SENATE BILL 337

January 25, 2008 – Offered by Senator SULLIVAN.

AN ACT ***to amend*** 40.51 (8), 40.51 (8m), 66.0137 (4), 120.13 (2) (g), 185.981 (4t) and 185.983 (1) (intro.); and ***to create*** 146.903, 609.71 and 632.798 of the statutes; **relating to:** disclosure of information by health care providers and insurers and providing a penalty.

Analysis by the Legislative Reference Bureau

This substitute amendment requires health care providers, as defined in the substitute amendment, to provide health care consumers with certain charge or payment rate information, upon request by and at no cost to the consumers; the information must be updated annually and may not be construed as a legally binding estimate. Under the substitute amendment, a health care provider must, within a reasonable period of time after a consumer's request, provide the consumer with the median billed charges (as defined in the substitute amendment), assuming no complications, for inpatient or outpatient health care services, diagnostic tests, or procedures provided by the health care provider that the consumer specifies. In addition, upon request, the health care provider must immediately, on site, provide the consumer with all of the following information, as a single document:

1. The median billed charge, assuming no medical complications, for each of 25 health care services, diagnostic tests, or procedures, relevant to the treatment of particular presenting conditions, as specified annually by the Department of Health and Family Services (DHFS). This information must be classified by

diagnosis–related groups or all–patient refined diagnosis–related groups, if provided by a hospital for inpatient services; by surgical procedure code, if provided by a hospital for outpatient services or if provided by an ambulatory surgery center; by presenting conditions, if provided by a physician; and by a grouping form similar to that for a hospital or a physician, if provided by a health care provider that is not a hospital or a physician.

2. If the health care provider is certified as a provider of Medical Assistance (MA), the MA payment rates for the provider's 25 most frequently performed health care services, diagnostic tests, or procedures.

3. If the health care provider is certified as a provider of Medicare, the Medicare payment rates for the provider's 25 most frequently performed health care services, diagnostic tests, or procedures.

4. The average allowable payment from private, third–party payers for the provider's 25 most frequently performed health care services, diagnostic tests, or procedures.

Under the substitute amendment, a violation of these requirements is subject to an administrative forfeiture of up to ~~$500~~.

Under the substitute amendment, a self–insured health plan of the state or a county, city, village, town, or school district, or an insurer that provides coverage under a health insurance policy, including defined network plans and sickness care plans operated by cooperative associations, must provide to an insured under the health insurance policy or an enrollee under the self–insured health plan a good faith estimate of the median reimbursement that the insurer or self–insured health plan would expect to pay for a specified health care service in the geographic region in which the service will be provided. In addition, the insurer or self–insured health plan must provide to an insured or enrollee a good faith estimate of the insured's or enrollee's total out–of–pocket cost for the specified service. The information must be provided only if the insured or enrollee requests it, and it must be provided at no charge to the insured or enrollee. Before providing any of the information, the insurer or self–insured health plan may require the insured or enrollee to provide the name of the provider providing the service, the facility at which the service will be provided, the date the service will be provided, and the provider's estimate of the charges. However, the insurer or self–insured health plan may not require the insured or enrollee to provide the Current Procedural Terminology code or Current Dental Terminology code for the service as a condition of providing the information. In addition, the substitute amendment provides that any good faith estimate provided is not a legally binding estimate.

The substitute amendment also requires health care providers to display prominently statements informing health care consumers of the consumers' right to request charge or payment rate information for health care services, diagnostic tests, or procedures from the health care providers or from their insurers.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 40.51 (8) of the statutes, as affected by 2007 Wisconsin Act 36, is amended to read:

40.51 **(8)** Every health care coverage plan offered by the state under sub. (6) shall comply with ss. 631.89, 631.90, 631.93 (2), 631.95, 632.72 (2), 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, 632.87 (3) to ~~(5)~~ (6), 632.895 (5m) and (8) to (15), and 632.896.

SECTION 2. 40.51 (8m) of the statutes, as affected by 2007 Wisconsin Act 36, is amended to read:

40.51 **(8m)** Every health care coverage plan offered by the group insurance board under sub. (7) shall comply with ss. 631.95, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, and 632.895 (11) to (15).

SECTION 3. 66.0137 (4) of the statutes, as affected by 2007 Wisconsin Act 36, is amended to read:

66.0137 **(4)** SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or a village provides health care benefits under its home rule power, or if a town provides health care benefits, to its officers and employees on a self-insured basis, the self-insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.87 (4) ~~and~~, (5), and (6), 632.895 (9) to (15), 632.896, and ~~767.25 (4m) (d)~~ 767.513 (4).

SECTION 4. 120.13 (2) (g) of the statutes, as affected by 2007 Wisconsin Act 36, is amended to read:

120.13 **(2)** (g) Every self-insured plan under par. (b) shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.87 (4) ~~and~~, (5), and (6), 632.895 (9) to (15), 632.896, and ~~767.25 (4m) (d)~~ 767.513 (4).

Grant 3-25 →

SECTION 5. 146.903 of the statutes is created to read:

146.903 Disclosures required of health care providers. (1) In this section:

(a) "All–patient refined diagnosis–related groups" means a system of classifying inpatient hospital discharges that applies to patients of any age and distinguishes among 4 levels of severity of illness within each classification.

(b) "Ambulatory surgery center" has the meaning given in 42 CFR 416.2.

(c) "Clinic" means a place, other than a residence, that is used primarily for the provision of nursing, medical, podiatric, dental, chiropractic, or optometric care and treatment.

(d) "Diagnosis–related groups" means a classification of inpatient hospital discharges specified under 42 CFR 412.60.

(e) "Health care provider" has the meaning given in s. 146.81 (1) and includes a clinic and an ambulatory surgery center.

(f) "Median billed charge" means the amount that a health care provider charged for a health care service, diagnostic test, or procedure, before any discount or contractual rate applicable to certain patients or payers was applied, during the first 2 calendar quarters of the most recently completed calendar year, as calculated by arranging the charges in that reporting period from highest to lowest and selecting the middle charge in the sequence or, for an even number of charges, selecting the 2 middle charges in the sequence and calculating the average of the 2.

(g) "Medical Assistance" means health care benefits provided under subch. IV of ch. 49.

(h) "Medicare" means coverage under part A or part B of Title XVIII of the federal Social Security Act, 42 USC 1395 to 1395dd.

(3) (a) Except as provided in sub. (5), a health care provider or the health care provider's designee shall, upon request by and at no cost to a health care consumer, disclose to the consumer all of the following, under the following circumstances:

(a) Within a reasonable period of time after the request, the median billed charge, assuming no medical complications, for an inpatient or outpatient health care service, diagnostic test, or procedure that is specified by the consumer and that is provided by the health care provider.

(b) Immediately upon request, on the site of the health care provider, as a single document, all of the following:

1. The median billed charge, assuming no medical complications, for each of 25 health care services, diagnostic tests, or procedures, relevant to the treatment of particular presenting conditions, as specified annually by the department based on claims data under Medical Assistance from the most recently–completed fiscal year. The information under this subdivision shall be classified as follows:

a. If provided concerning inpatient services by a hospital, by diagnosis–related groups or all–patient refined diagnosis–related groups.

b. If provided concerning outpatient services by a hospital, or if provided by an ambulatory surgery center, by surgical procedure code.

c. If provided by a physician, under a classification of physician specialities that is specified by the department, by presenting conditions, including the total charges for codes under the Current Procedural Terminology of the American Medical Association that are most frequently performed as a result of the presenting conditions. "Presenting conditions" under this subd. 1. c. shall be defined by the department after consulting with the Wisconsin Collaborative for Healthcare Quality.

d. If provided by a health care provider other than a hospital or physician, by a grouping form similar to that under subd. 1. a., b., or c. Notwithstanding the requirement under subd. 1. (intro.) that 25 health care services, diagnostic tests, or procedures be disclosed, if the health care provider under this subd. 1. d. performs fewer than 25 health care services, diagnostic tests, or procedures on a regular basis, the health care provider shall indicate that fact and disclose those health care services, diagnostic tests, or procedures that the health care provider performs on a regular basis.

2. If the health care provider is certified as a provider of Medical Assistance, the Medical Assistance payment rates for the provider for the health care services, diagnostic tests, or procedures specified in subd. 1.

3. If the health care provider is certified as a provider of Medicare, the Medicare payment rates for the provider for the health care services, diagnostic tests, or procedures specified in subd. 1.

4. The average allowable payment from private, 3rd–party payers for the health care services, diagnostic tests, or procedures specified in subd. 1.

(3) Information on charges or payment rates that is provided to a health care consumer under sub. (2) shall be updated annually by the health care provider and may not be construed as a legally binding estimate of the cost to the consumer.

(4) Except as provided in sub. (5), a health care provider shall prominently display, in the area of the health care provider's practice or facility that is most commonly frequented by health care consumers, a statement informing the consumers that they have the right to request charge or payment rate information for health care services, diagnostic tests, or procedures from the health care provider

or, if the requirements under s. 632.798 (2) (e) are met, all of the following from their insurers or self–insured health plans:

(a) A good faith estimate of the median reimbursement that the insurer or self–insured health plan would expect to pay for a specified health care service in the geographic region in which the health care service will be provided.

(b) A good faith estimate of the insured's total out–of–pocket cost according to the insured's benefit terms for the specified health care service in the geographic region in which the health care service will be provided.

Bold → (6) (5) This section does not apply to any of the following:

(a) A health care provider that practices individually and not in association with another health care provider.

(b) Health care providers that are an association of 3 or fewer individual health care providers.

Bold → (7) (6) (a) Whoever violates this section may be required to forfeit not more than $500 for each violation.

(b) The department may directly assess forfeitures provided for under par. (a). If the department determines that a forfeiture should be assessed for a particular violation, the department shall send a notice of assessment to the alleged violator. The notice shall specify the amount of the forfeiture assessed, the violation, and the statute or rule alleged to have been violated, and shall inform the alleged violator of the right to a hearing under par. (c).

(c) An alleged violator may contest an assessment of a forfeiture by sending, within 10 days after receipt of notice under par. (b), a written request for a hearing under s. 227.44 to the division of hearings and appeals created under s. 15.103 (1). The administrator of the division may designate a hearing examiner to preside over

the case and recommend a decision to the administrator under s. 227.46. The decision of the administrator of the division shall be the final administrative decision. The division shall commence the hearing within 30 days after receipt of the request for a hearing and shall issue a final decision within 15 days after the close of the hearing. Proceedings before the division are governed by ch. 227. In any petition for judicial review of a decision by the division, the party, other than the petitioner, who was in the proceeding before the division shall be the named respondent.

(d) All forfeitures shall be paid to the department within 10 days after receipt of notice of assessment or, if the forfeiture is contested under par. (c), within 10 days after receipt of the final decision after exhaustion of administrative review, unless the final decision is appealed and the order is stayed by court order. The department shall remit all forfeitures paid to the secretary of administration for deposit in the school fund.

(e) The attorney general may bring an action in the name of the state to collect any forfeiture imposed under this subsection if the forfeiture has not been paid following the exhaustion of all administrative and judicial reviews. The only issue to be contested in any such action is whether the forfeiture has been paid.

SECTION 6. 185.981 (4t) of the statutes, as affected by 2007 Wisconsin Act 36, is amended to read:

185.981 **(4t)** A sickness care plan operated by a cooperative association is subject to ss. 252.14, 631.17, ~~631.89, 631.95, 632.72 (2), 632.745~~ to 632.749, 632.798, 632.85, 632.853, ~~632.855~~, 632.87 (2m), (3), (4), ~~and~~ (5), and (6), 632.895 (10) to (15), and 632.897 (10) and chs. 149 and 155.

SECTION 7. 185.983 (1) (intro.) of the statutes, as affected by 2007 Wisconsin Act 36, is amended to read:

185.983 **(1)** (intro.) Every such voluntary nonprofit sickness care plan shall be exempt from chs. 600 to 646, with the ~~exception of ss.~~ 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44, 601.45, 611.67, 619.04, 628.34 (10), 631.17, 631.89, 631.93, 631.95, 632.72 (2), 632.745 to 632.749, 632.775, 632.79, 632.795, 632.798, 632.85, 632.853, 632.855, 632.87 (2m), (3), (4), ~~and~~ (5), and (6), 632.895 (5) and (9) to (15), 632.896, and 632.897 (10) and chs. 609, 630, 635, 645, and 646, but the sponsoring association shall:

SECTION 8. 609.71 of the statutes is created to read:

609.71 Disclosure of payments. Limited service health organizations, preferred provider plans, and defined network plans are subject to s. 632.798.

SECTION 9. 632.798 of the statutes is created to read:

632.798 Disclosure of payments. (1) DEFINITIONS. In this section:

(a) "Disability insurance policy" has the meaning given in s. 632.895 (1) (a).

(b) "Insured" includes an enrollee under a self–insured health plan and a representative or designee of an insured or enrollee.

(c) "Self–insured health plan" means a self–insured health plan of the state or a county, city, village, town, or school district.

(2) PROVIDE INFORMATION. (a) A self–insured health plan or an insurer that provides coverage under a disability insurance policy shall, at the request of an insured, provide to the insured a good faith estimate of the median reimbursement that the insurer or self–insured health plan would expect to pay for a specified health care service in the geographic region in which the health care service will be provided.

(b) If requested by the insured, the insurer or self–insured health plan under par. (a) shall also provide to the insured a good faith estimate, as of the date of the request, of the insured's total out–of–pocket cost according to the insured's benefit terms for the specified health care service in the geographic region in which the health care service will be provided.

(c) An estimate provided by an insurer or self–insured health plan under this section is not a legally binding estimate of the reimbursement or out–of–pocket cost.

(d) An insurer or self–insured health plan may not charge an insured for providing the information under this section.

(e) 1. Before providing any of the information requested under par. (a) or (b), the insurer or self–insured health plan may require the insured to provide any of the following information:

a. The name of the provider providing the service.

b. The facility at which the service will be provided.

c. The date the service will be provided.

d. The provider's estimate of the charge for the service.

2. The insurer or self–insured health plan may not require an insured to provide the code for the service under the Current Procedural Terminology of the American Medical Association or under the Current Dental Terminology of the American Dental Association as a condition for providing the information requested under par. (a) or (b).

SECTION 10. Initial applicability.

(1) DISCLOSURE OF CHARGES, PAYMENTS, AND OUT–OF–POCKET COSTS. If a disability insurance policy or a governmental self–insured health plan that is in effect on the effective date of this subsection, or a contract or agreement between a provider and

a health care plan that is in effect on the effective date of this subsection, contains a provision that is inconsistent with this act, this act first applies to that disability insurance policy, governmental self–insured health plan, or contract or agreement on the date on which it is modified, extended, or renewed.

SECTION 11. Effective date.

(1) This act takes effect on the first day of the 10th month beginning after publication.

(END)

Analysis insert:

This bill requires a health care provider to disclose to a consumer the provider's median billed charge for a health care service, diagnostic test, or procedure, upon request.

The bill also requires a health care provider to disclose specified charge information for 25 presenting conditions. The bill requires the Department of Health Services to determine the 25 most common presenting conditions based on Medical Assistance claims data. Under the bill, a health care provider must create a document that lists charge information for diagnosing and treating each of the 25 conditions for which the health care provider regularly provides service. The health care provider must list the following applicable charge information for each presenting condition: 1) the median billed charge; 2) the reimbursement amount under Medical Assistance, if the health care provider participates in the Medical Assistance Program; 3) the reimbursement rate under Medicare, if the provider participates in Medicare; and 4) the average allowable payment from private, 3rd-party payers. A health care provider must prominently display the document in the provider's facility, and must update it annually.

Under the bill, these provisions relating to disclosing charge information apply to health care facilities such as a hospital, ambulatory surgical center, or nursing home, and to associations of health care provides that include four or more practitioners.

Ins 4-25:

(2) IDENTIFICATION OF COMMON PRESENTING CONDITIONS. Using claims data for Medical Assistance, the department shall annually identify the 25 most common health conditions presented by medical assistance recipients to health care providers.

Ins 5-7:

(4) SUMMARY OF CHARGES FOR COMMON SERVICES. (a) Except as provided in sub. (6), a health care provider shall prepare a single document that lists the following

charge information for diagnosing and treating each of the conditions identified under sub. (2) for which the health care provider regularly provides services:

1. The median billed charge, classified as follows:

a. For an inpatient health care service, diagnostic test, or procedure provided by a hospital, by diagnosis-related groups or all-patient refined diagnosis-related groups.

b. For an outpatient health care service, diagnostic test, or procedure provided by a hospital, or if provided by an ambulatory surgical center, by surgical procedure code.

Ins 6-16:

(b) Except as provided in sub. (6), a health care provider or the health care provider's designee shall, upon request by and at no cost to a health care consumer, provide the consumer a copy of the document prepared under par. (a).

(c) A health care provider shall annually update the document under par. (a).

(d) Charge information included on the document under par. (a) does not constitute a legally binding estimate of the cost to the consumer.

INSERT 3-25

SECTION 1. 40.51 (8) of the statutes, as affected by 2009 Wisconsin Act 14, is amended to read:

40.51 **(8)** Every health care coverage plan offered by the state under sub. (6) shall comply with ss. 631.89, 631.90, 631.93 (2), 631.95, 632.72 (2), 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, 632.87 (3) to (6), 632.895 (5m) and (8) to (16), and 632.896.

History: 2009 a. 14.

SECTION 2. 40.51 (8m) of the statutes, as affected by 2009 Wisconsin Act 14, is amended to read:

40.51 **(8m)** Every health care coverage plan offered by the group insurance board under sub. (7) shall comply with ss. 631.95, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, and 632.895 (11) to (16).

History: 2009 a. 14.

SECTION 3. 66.0137 (4) of the statutes, as affected by 2009 Wisconsin Act 14, is amended to read:

66.0137 **(4)** SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or a village provides health care benefits under its home rule power, or if a town provides health care benefits, to its officers and employees on a self-insured basis, the self-insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.87 (4), (5), and (6), 632.895 (9) to (16), 632.896, and 767.513 (4).

History: 2009 a. 14.

SECTION 4. 120.13 (2) (g) of the statutes, as affected by 2009 Wisconsin Act 14, is amended to read:

Ins 3-25 cont'd

120.13 **(2)** (g) Every self-insured plan under par. (b) shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.87 (4), (5), and (6), 632.895 (9) to (16), 632.896, and 767.513 (4).

History: 2009 a. 14.

(END OF INSERT 3-25)

INSERT 9-9

SECTION 5. 185.981 (4t) of the statutes, as affected by 2009 Wisconsin Act 14, is amended to read:

185.981 **(4t)** A sickness care plan operated by a cooperative association is subject to ss. 252.14, 631.17, 631.89, 631.95, 632.72 (2), 632.745 to 632.749, 632.798, 632.85, 632.853, 632.855, 632.87 (2m), (3), (4), (5), and (6), 632.895 (10) to (16), and 632.897 (10) and chs. 149 and 155.

History: 2009 a. 14.

SECTION 6. 185.983 (1) (intro.) of the statutes, as affected by 2009 Wisconsin Act 14, is amended to read:

185.983 **(1)** (intro.) Every such voluntary nonprofit sickness care plan shall be exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44, 601.45, 611.67, 619.04, 628.34 (10), 631.17, 631.89, 631.93, 631.95, 632.72 (2), 632.745 to 632.749, 632.775, 632.79, 632.795, 632.798, 632.85, 632.853, 632.855, 632.87 (2m), (3), (4), (5), and (6), 632.895 (5) and (9) to (16), 632.896, and 632.897 (10) and chs. 609, 630, 635, 645, and 646, but the sponsoring association shall:

History: 2009 a. 14.

(END OF INSERT 9-9)

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-0271/P1dn
RLR:

SJS

-date-

Nicole Hudzinski:

This is a redraft of 2007 Senate Substitute Amendment 1 to Senate Bill 337 (SSA 1). As we discussed, this draft requires DHS to identify the 25 most common "presenting conditions" from Medical Assistance claims data. I do not know whether DHS currently receives sufficient information from health care providers to identify presenting conditions, as opposed to billed services.

The draft requires DHS to establish a single set of the 25 most common presenting conditions that applies to all health care providers. In practice that list may include some items that are common for primary care physicians, such as sore throat or annual physical, and some that would only be relevant to a hospital, such as scheduled in-patient surgery, or an emergency room visit for chest pain. Is this what you intend?

The draft requires hospitals and ambulatory surgical centers to list median billed charges by service, test, and procedure for each presenting conditions, but requires physicians to list median billed charges by "presenting conditions" without identifying services, tests, or procedures. Is this difference in the reporting requirement intentional? The draft is unclear whether health care providers should list Medical Assistance, Medicare, and 3rd-party rates by service, test, and procedure, or by condition.

SSA 1 required that DHS consult with the Wisconsin Collaborative for Healthcare Quality to define "presenting conditions" for purposes of determining the form in which physicians identify median billed charges. Given that this redraft requires DHS to identity the 25 most common "presenting conditions," what role, if any, should the draft assign to the Collaborative with respect to defining or identifying "presenting conditions?"

The bill applies to a "health care provider" as defined in s. 146.81 (1). Please verify that you want the bill to apply to all the types of providers listed in that definition, for example, physical therapists, pharmacists, and nursing homes.

Robin Ryan
Legislative Attorney
Phone: (608) 261-6927
E-mail: robin.ryan@legis.wisconsin.gov

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-3042/P1dn
RLR:cjs:ph

June 25, 2009

Nicole Hudzinski:

This is a redraft of 2007 Senate Substitute Amendment 1 to Senate Bill 337 (SSA 1). As we discussed, this draft requires DHS to identify the 25 most common "presenting conditions" from Medical Assistance claims data. I do not know whether DHS currently receives sufficient information from health care providers to identify presenting conditions, as opposed to billed services.

The draft requires DHS to establish a single set of the 25 most common presenting conditions that applies to all health care providers. In practice that list may include some items that are common for primary care physicians, such as sore throat or annual physical, and some that would only be relevant to a hospital, such as scheduled in-patient surgery, or an emergency room visit for chest pain. Is this what you intend?

The draft requires hospitals and ambulatory surgical centers to list median billed charges by service, test, and procedure for each presenting conditions, but requires physicians to list median billed charges by "presenting condition" without identifying services, tests, or procedures. Is this difference in the reporting requirement intentional? The draft is unclear whether health care providers should list Medical Assistance, Medicare, and 3rd-party rates by service, test, and procedure, or by condition.

SSA 1 required that DHS consult with the Wisconsin Collaborative for Healthcare Quality to define "presenting conditions" for purposes of determining the form in which physicians identify median billed charges. Given that this redraft requires DHS to identity the 25 most common "presenting conditions," what role, if any, should the draft assign to the Collaborative with respect to defining or identifying "presenting conditions"?

The bill applies to a "health care provider" as defined in s. 146.81 (1). Please verify that you want the bill to apply to all the types of providers listed in that definition, for example, physical therapists, pharmacists, and nursing homes.

Robin Ryan
Legislative Attorney
Phone: (608) 261-6927
E-mail: robin.ryan@legis.wisconsin.gov

Ryan, Robin

From: Hudzinski, Nicole
Sent: Tuesday, October 27, 2009 1:43 PM
To: Ryan, Robin
Cc: Kostelic, Jeff
Subject: LRB 3042

Hi Robin—

The intent of the legislation is to have each health care facility provide a list of the top 25 'presenting conditions' they perform most frequently. So if it's a doctor's office, the list would include things like annual physical, well baby check, etc. And if it's a hospital, it would include things like knee surgery, vaginal delivery, etc. And if it's a dentist's office, it would include things like a cleaning, filling, etc. Kind of like a menu, and similar to those clinics popping up in Walmart (http://www.walmart.com/clinics)

DHS is the entity that we want responsible for setting the list for each facility. And in order to make sure consumers have apples to apples comparisons, we want DHS, in consultation with the WI Collaborative for Healthcare Quality, to define how each 'presenting condition' should be calculated (i.e. CPT code X + CPT code Y= sinus infection).

Does that make sense and answer your question about the role of DHS and the WI Collaborative?

Regarding the difference between hospitals, ambulatory surgiacal center, and physicians, the intent is for everyone to report on 'presenting conditions' as set by DHS and defined by DHS and the Collaborative.

Regarding the definition of 'health care provider', yes, we do want it to apply to all types of providers.

One change we want made to the draft is to allow health plans to require the enrollee to provide the list of CPT codes expected to be performed before they are required to give an estimate of the median billed charge or an estimate of out-of-pocket costs. Currently the draft prohibits the health plan from requiring CPT codes (page 10, line 4).

I have cc'ed Jeff from Rep. Richards office on this email. Rep. Richards is going to be our assembly lead, so please feel free to discuss the draft with his office. I believe they also want to introduce an assembly companion also.

How quickly do you think you can get these changes done? We are hoping to circulate by the end of the week.

Thanks,
Nicole

Sections Affected Post–Drafting–Check For 09–3042/P1

Tuesday, November 3, 2009 11:15 am

Current Wisconsin Statutes updated through 2009 Act 57

CITATION	TREATMENT	AFFECTED BY
40.51 (8)	am. effec. 1–1–2010	Act 14, s. 1
40.51 (8) (aff. 2009 WisAct 14)		am. effec. 1–1–2010
Act 28, s. 801r		
40.51 (8m)	am. effec. 1–1–2010	Act 14, s. 2
40.51 (8m) (aff. 2009 WisAct 14)		am. effec. 1–1–2010
Act 28, s. 801t		
66.0137 (4)	am. effec. 1–1–2010	Act 14, s. 3
66.0137 (4) (aff. 2009 WisAct 14)		am. effec. 1–1–2010
Act 28, s. 1463w		
120.13 (2) (g)	am. effec. 1–1–2010	Act 14, s. 5
120.13 (2) (g) (aff. 2009 WisAct 14)		am. effec. 1–1–2010
Act 28, s. 2297q		
185.981 (4t)	am. effec. 1–1–2010	Act 14, s. 6
185.981 (4t) (aff. 2009 WisAct 14)		am. effec. 1–1–2010
Act 28, s. 2453tm		
185.983 (1) (intro.)	am. effec. 1–1–2010	Act 14, s. 7
185.983 (1) (intro.) (aff. 2009 WisAct 14)		am. effec. 1–1–2010
Act 28, s. 2453u		

State of Wisconsin
2009 - 2010 LEGISLATURE

LRB-3042/P1
RLR&PJK:cjs:~~pk~~

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

AN ACT ***to amend*** 40.51 (8), 40.51 (8m), 66.0137 (4), 120.13 (2) (g), 185.981 (4t) and 185.983 (1) (intro.); and ***to create*** 146.903, 609.71 and 632.798 of the statutes; **relating to:** disclosure of information by health care providers and insurers and providing a penalty.

Analysis by the Legislative Reference Bureau

This bill requires a health care provider to disclose to a consumer the provider's median billed charge for a health care service, diagnostic test, or procedure, upon request.

The bill also requires a health care provider to disclose specified charge information for 25 presenting conditions. The bill requires the Department of Health Services to determine the 25 most common presenting conditions based on Medical Assistance claims data. Under the bill, a health care provider must create a document that lists charge information for diagnosing and treating each of the 25 conditions for which the health care provider regularly provides service. The health care provider must list the following applicable charge information for each presenting condition: 1) the median billed charge; 2) the reimbursement amount under Medical Assistance, if the health care provider participates in the Medical Assistance Program; 3) the reimbursement rate under Medicare, if the provider participates in Medicare; and 4) the average allowable payment from private, third-party payers. A health care provider must update the document annually.

Under the bill, these provisions relating to disclosing charge information apply to health care facilities such as a hospital, ambulatory surgical center, or nursing

home, and to associations of health care provides that include four or more practitioners.

Under the bill, a self-insured health plan of the state or a county, city, village, town, or school district, or an insurer that provides coverage under a health insurance policy, including defined network plans and sickness care plans operated by cooperative associations, must provide to an insured under the health insurance policy or an enrollee under the self-insured health plan a good faith estimate of the median reimbursement that the insurer or self-insured health plan would expect to pay for a specified health care service in the geographic region in which the service will be provided. In addition, the insurer or self-insured health plan must provide to an insured or enrollee a good faith estimate of the insured's or enrollee's total out-of-pocket cost for the specified service. The information must be provided only if the insured or enrollee requests it, and it must be provided at no charge to the insured or enrollee. Before providing any of the information, the insurer or self-insured health plan may require the insured or enrollee to provide the name of the provider providing the service, the facility at which the service will be provided, the date the service will be provided, and the provider's estimate of the charges. However, the insurer or self-insured health plan may not require the insured or enrollee to provide the Current Procedural Terminology code or Current Dental Terminology code for the service as a condition of providing the information. In addition, the bill provides that any good faith estimate provided is not a legally binding estimate.

The bill also requires health care providers to display prominently statements informing health care consumers of the consumers' right to request charge information from the health care providers or from their insurers.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 40.51 (8) of the statutes, as affected by 2009 Wisconsin Act 14, is amended to read:

40.51 **(8)** Every health care coverage plan offered by the state under sub. (6) shall comply with ss. 631.89, 631.90, 631.93 (2), 631.95, 632.72 (2), 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, 632.87 (3) to (6), 632.895 (5m) and (8) to (16), and 632.896.

SECTION 2. 40.51 (8m) of the statutes, as affected by 2009 Wisconsin Act 14, is amended to read:

40.51 **(8m)** Every health care coverage plan offered by the group insurance board under sub. (7) shall comply with ss. 631.95, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, and 632.895 (11) to (16).

SECTION 3. 66.0137 (4) of the statutes, as affected by 2009 Wisconsin Act 14, is amended to read:

66.0137 **(4)** SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or a village provides health care benefits under its home rule power, or if a town provides health care benefits, to its officers and employees on a self-insured basis, the self-insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.87 (4), (5), and (6), 632.895 (9) to (16), 632.896, and 767.513 (4).

SECTION 4. 120.13 (2) (g) of the statutes, as affected by 2009 Wisconsin Act 14, is amended to read:

120.13 **(2)** (g) Every self-insured plan under par. (b) shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.87 (4), (5), and (6), 632.895 (9) to (16), 632.896, and 767.513 (4).

SECTION 5. 146.903 of the statutes is created to read:

146.903 Disclosures required of health care providers. (1) DEFINITIONS. In this section:

(a) "All-patient refined diagnosis-related groups" means a system of classifying inpatient hospital discharges that applies to patients of any age and distinguishes among 4 levels of severity of illness within each classification.

(c) (b) "Ambulatory surgical center" has the meaning given in 42 CFR 416.2.

(b) (c) "Clinic" means a place, other than a residence, that is used primarily for the provision of nursing, medical, podiatric, dental, chiropractic, or optometric care and treatment.

(d) "Diagnosis-related groups" means a classification of inpatient hospital discharges specified under 42 CFR 412.60.

(c) (e) "Health care provider" has the meaning given in s. 146.81 (1) (a) to (p) and includes a clinic and an ambulatory surgical center.

(d) (f) "Median billed charge" means the amount that a health care provider charged for a health care service, diagnostic test, or procedure, before any discount or contractual rate applicable to certain patients or payers was applied, during the first 2 calendar quarters of the most recently completed calendar year, as calculated by arranging the charges in that reporting period from highest to lowest and selecting the middle charge in the sequence or, for an even number of charges, selecting the 2 middle charges in the sequence and calculating the average of the 2.

(e) (g) "Medical Assistance" means health care benefits provided under subch. IV of ch. 49.

(f) (h) "Medicare" means coverage under part A or part B of Title XVIII of the federal Social Security Act, 42 USC 1395 to 1395dd.

(2) IDENTIFICATION OF COMMON PRESENTING CONDITIONS. Using claims data for Medical Assistance, the department shall annually identify the 25 most common presenting conditions among Medical Assistance recipients.

INS 4-21

(3) CHARGE FOR A SERVICE. Except as provided in sub. (6), a health care provider or the health care provider's designee shall, upon request by and at no cost to a health care consumer, disclose to the consumer within a reasonable period of time after the request, the median billed charge, assuming no medical complications, for an

inpatient or outpatient health care service, diagnostic test, or procedure that is specified by the consumer and that is provided by the health care provider.

(4) SUMMARY OF CHARGES FOR COMMON SERVICES. (a) Except as provided in sub. (6), a health care provider shall prepare a single document that lists the following charge information for diagnosing and treating each of the conditions identified under sub. (2) for which the health care provider regularly provides services:

1. The median billed charge, classified as follows:

a. For an inpatient health care service, diagnostic test, or procedure provided by a hospital, by diagnosis-related groups or all-patient refined diagnosis-related groups.

b. For an outpatient health care service, diagnostic test, or procedure provided by a hospital, or if provided by an ambulatory surgical center, by surgical procedure code.

c. For services provided by a physician, under a classification of physician specialities that is specified by the department, by presenting conditions, including the total charges for codes under the Current Procedural Terminology of the American Medical Association that are most frequently performed as a result of the presenting conditions.

d. For services provided by a health care provider other than a hospital or physician, under a classification similar to that under subd. 1. a., b., or c.

2. If the health care provider is certified as a provider of Medical Assistance, the Medical Assistance payment rates for the provider.

3. If the health care provider is certified as a provider of Medicare, the Medicare payment rates for the provider.

4. The average allowable payment from private, 3rd-party payers.

(b) Except as provided in sub. (6), a health care provider or the health care provider's designee shall, upon request by and at no cost to a health care consumer, provide the consumer a copy of the document prepared under par. (a).

(c) A health care provider shall annually update the document under par. (a).

(d) Charge information included on the document under par. (a) does not constitute a legally binding estimate of the cost to the consumer.

(5) NOTICE. Except as provided in sub. (6), a health care provider shall prominently display, in the area of the health care provider's practice or facility that is most commonly frequented by health care consumers, a statement informing the consumers that they have the right to request charge information from the health care provider or, if the requirements under s. 632.798 (2) (e) are met, all of the following from their insurers or self-insured health plans:

(a) A good faith estimate of the median reimbursement that the insurer or self-insured health plan would expect to pay for a specified health care service in the geographic region in which the health care service will be provided.

(b) A good faith estimate of the insured's total out-of-pocket cost according to the insured's benefit terms for the specified health care service in the geographic region in which the health care service will be provided.

(6) APPLICABILITY TO HEALTH CARE PROVIDERS. The requirements under subs. (3) to (5) do not apply to any of the following:

(a) A health care provider that practices individually and not in association with another health care provider.

(b) Health care providers that are an association of 3 or fewer individual health care providers.

(7) PENALTY. (a) Whoever violates this section may be required to forfeit not more than $500 for each violation.

(b) The department may directly assess forfeitures provided for under par. (a). If the department determines that a forfeiture should be assessed for a particular violation, the department shall send a notice of assessment to the alleged violator. The notice shall specify the amount of the forfeiture assessed, the violation, and the statute or rule alleged to have been violated, and shall inform the alleged violator of the right to a hearing under par. (c).

(c) An alleged violator may contest an assessment of a forfeiture by sending, within 10 days after receipt of notice under par. (b), a written request for a hearing under s. 227.44 to the division of hearings and appeals created under s. 15.103 (1). The administrator of the division may designate a hearing examiner to preside over the case and recommend a decision to the administrator under s. 227.46. The decision of the administrator of the division shall be the final administrative decision. The division shall commence the hearing within 30 days after receipt of the request for a hearing and shall issue a final decision within 15 days after the close of the hearing. Proceedings before the division are governed by ch. 227. In any petition for judicial review of a decision by the division, the party, other than the petitioner, who was in the proceeding before the division shall be the named respondent.

(d) All forfeitures shall be paid to the department within 10 days after receipt of notice of assessment or, if the forfeiture is contested under par. (c), within 10 days after receipt of the final decision after exhaustion of administrative review, unless the final decision is appealed and the order is stayed by court order. The department

shall remit all forfeitures paid to the secretary of administration for deposit in the school fund.

(e) The attorney general may bring an action in the name of the state to collect any forfeiture imposed under this subsection if the forfeiture has not been paid following the exhaustion of all administrative and judicial reviews. The only issue to be contested in any such action is whether the forfeiture has been paid.

SECTION 6. 185.981 (4t) of the statutes, as affected by 2009 Wisconsin Act 14, is amended to read:

185.981 **(4t)** A sickness care plan operated by a cooperative association is subject to ss. 252.14, 631.17, 631.89, 631.95, 632.72 (2), 632.745 to 632.749, 632.798, 632.85, 632.853, 632.855, 632.87 (2m), (3), (4), (5), and (6), 632.895 (10) to (16), and 632.897 (10) and chs. 149 and 155.

SECTION 7. 185.983 (1) (intro.) of the statutes, as affected by 2009 Wisconsin Act 14, is amended to read:

185.983 **(1)** (intro.) Every such voluntary nonprofit sickness care plan shall be exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44, 601.45, 611.67, 619.04, 628.34 (10), 631.17, 631.89, 631.93, 631.95, 632.72 (2), 632.745 to 632.749, 632.775, 632.79, 632.795, 632.798, 632.85, 632.853, 632.855, 632.87 (2m), (3), (4), (5), and (6), 632.895 (5) and (9) to (16), 632.896, and 632.897 (10) and chs. 609, 630, 635, 645, and 646, but the sponsoring association shall:

Insert 8-21

SECTION 8. 609.71 of the statutes is created to read:

609.71 Disclosure of payments. Limited service health organizations, preferred provider plans, and defined network plans are subject to s. 632.798.

SECTION 9. 632.798 of the statutes is created to read:

632.798 Disclosure of payments. (1) DEFINITIONS. In this section:

(a) "Disability insurance policy" has the meaning given in s. 632.895 (1) (a).

(b) "Insured" includes an enrollee under a self-insured health plan and a representative or designee of an insured or enrollee.

(c) "Self-insured health plan" means a self-insured health plan of the state or a county, city, village, town, or school district.

(2) PROVIDE INFORMATION. (a) A self-insured health plan or an insurer that provides coverage under a disability insurance policy shall, at the request of an insured, provide to the insured a good faith estimate of the median reimbursement that the insurer or self-insured health plan would expect to pay for a specified health care service in the geographic region in which the health care service will be provided.

(b) If requested by the insured, the insurer or self-insured health plan under par. (a) shall also provide to the insured a good faith estimate, as of the date of the request, of the insured's total out-of-pocket cost according to the insured's benefit terms for the specified health care service in the geographic region in which the health care service will be provided.

(c) An estimate provided by an insurer or self-insured health plan under this section is not a legally binding estimate of the reimbursement or out-of-pocket cost.

(d) An insurer or self-insured health plan may not charge an insured for providing the information under this section.

(e) 1. Before providing any of the information requested under par. (a) or (b), the insurer or self-insured health plan may require the insured to provide any of the following information:

a. The name of the provider providing the service.

2. The facility at which the service will be provided.

3. The date the service will be provided.

4. The provider's estimate of the charge for the service.

5. The insurer or self-insured health plan may not require an insured to provide the code for the service under the Current Procedural Terminology of the American Medical Association or under the Current Dental Terminology of the American Dental Association as a condition for providing the information requested under par. (a) or (b).

SECTION 10. Initial applicability.

(1) DISCLOSURE OF CHARGES, PAYMENTS, AND OUT-OF-POCKET COSTS. If a disability insurance policy or a governmental self-insured health plan that is in effect on the effective date of this subsection, or a contract or agreement between a provider and a health care plan that is in effect on the effective date of this subsection, contains a provision that is inconsistent with this act, this act first applies to that disability insurance policy, governmental self-insured health plan, or contract or agreement on the date on which it is modified, extended, or renewed.

SECTION 11. Effective date.

(1) This act takes effect on the first day of the 10th month beginning after publication.

(END)

Ins A:

The bill also requires a health care provider to disclose specified charge information for the 25 presenting conditions for which the provider most frequently provides services, as identified by the Department of Health Services (DHS). The bill requires DHS to consult with the Wisconsin Healthcare Collaborative for Healthcare Quality, and to use Medical Assistance claims data, in identifying the presenting conditions for each health care provider. Under the bill, a health care provider must create a document that lists the following charge information for diagnosing and treating each of the 25 presenting conditions identified by DHS for the provider: 1) the provider's median billed charges; 2) the reimbursement amount under Medical Assistance, if the health care provider participates in the Medical Assistance Program; 3) the reimbursement amount under Medicare, if the provider participates in Medicare; and 4) the average allowable payment from private, third-party payers. A health care provider must update the document annually.

Ins 4-21:

(2) DEPARTMENT DUTIES. (a) The department shall, for each health care provider that is required to comply with sub. (4), annually identify the 25 presenting conditions for which the health care provider most frequently provides health care services. The department shall use claims data for Medical Assistance and shall consult with the Wisconsin Collaborative for Healthcare Quality in identifying the presenting conditions.

(b) The department shall, after consulting with the Wisconsin Collaborative for Healthcare Quality, prescribe the methods by which a health care provider shall calculate and present median billed charges and Medical Assistance, Medicare, and private, 3rd-party payer payments for a presenting condition under this section.

INSERT 3-17 1672

SECTION 1. 40.51 (8) of the statutes, as affected by 2009 Wisconsin Act 28, is amended to read:

40.51 **(8)** Every health care coverage plan offered by the state under sub. (6) shall comply with ss. 631.89, 631.90, 631.93 (2), 631.95, 632.72 (2), 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, 632.87 (3) to (6), 632.885, 632.895 (5m) and (8) to (17), and 632.896.

NOTE: NOTE: Sub. (8) is shown as amended eff. 1-1-10 by 2009 Wis. Act 28. Prior to 1-1-10 it reads as follows. The correct cross-references are shown in brackets.NOTE:

(8) Every health care coverage plan offered by the state under sub. (6) shall comply with ss. 631.89, 631.90, 631.93 (2), 631.95, 632.72 (2), 632.746 (1) to (8) and (10), 632.747, 632.748, 632.83, 632.835, 632.85, 632.853, 632.855, 632.87 (3) to (5) [s. 632.87 (3) to (6)], 632.895 (5m) and (8) to (15), and 632.896.

History: 1981 c. 96; 1983 a. 27; 1985 a. 29; 1987 a. 27, 107, 356; 1987 a. 403 s. 256; 1989 a. 31, 93, 121, 129, 182, 201, 336, 359; 1991 a. 39, 70, 113, 152, 269, 315, 1993 a. 450, 481; 1995 a. 289; 1997 a. 27, 155, 202, 237, 252; 1999 a. 32, 95, 115, 155; 2001 a. 16, 38, 104; 2003 a. 33; 2005 a. 194; 2007 a. 36; 2009 a. 14, 28.

SECTION 2. 40.51 (8m) of the statutes, as affected by 2009 Wisconsin Act 28, is amended to read:

40.51 **(8m)** Every health care coverage plan offered by the group insurance board under sub. (7) shall comply with ss. 631.95, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, 632.885, and 632.895 (11) to (17).

NOTE: NOTE: Sub. (8m) is shown as amended eff. 1-1-10 by 2009 Wis. Act 28. Prior to 1-1-10 it reads:NOTE:

(8m) Every health care coverage plan offered by the group insurance board under sub. (7) shall comply with ss. 631.95, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.83, 632.835, 632.85, 632.853, 632.855, and 632.895 (11) to (15).

History: 1981 c. 96; 1983 a. 27; 1985 a. 29; 1987 a. 27, 107, 356; 1987 a. 403 s. 256; 1989 a. 31, 93, 121, 129, 182, 201, 336, 359; 1991 a. 39, 70, 113, 152, 269, 315, 1993 a. 450, 481; 1995 a. 289; 1997 a. 27, 155, 202, 237, 252; 1999 a. 32, 95, 115, 155; 2001 a. 16, 38, 104; 2003 a. 33; 2005 a. 194; 2007 a. 36; 2009 a. 14, 28.

SECTION 3. 66.0137 (4) of the statutes, as affected by 2009 Wisconsin Act 28, is amended to read:

66.0137 **(4)** SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or a village provides health care benefits under its home rule power, or if a town provides health care benefits, to its officers and employees on a self-insured basis, the self-insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2),

ins 3-17 cont'd 2 of 2

632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.87 (4), (5), and (6), 632.885, 632.895 (9) to (17), 632.896, and 767.513 (4).

NOTE: NOTE: Sub. (4) is shown as amended eff. 1-1-10 by 2009 Wis. Act 28. Prior to 1-1-10 it reads as follows. The correct cross-references are shown in brackets.NOTE:

(4) SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or a village provides health care benefits under its home rule power, or if a town provides health care benefits, to its officers and employees on a self-insured basis, the self-insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.85, 632.853, 632.855, 632.87 (4), and (5) [s. 632.87 (4), (5), and (6)], 632.895 (9) to (15), 632.896, and 767.25 (4m) (d) [s. 767.513 (4)].

History: 1999 a. 9, 115; 1999 a. 150 ss. 34, 305 to 306; Stats. 1999 s. 66.0137; 1999 a. 186 s. 63; 2001 a. 16, 30; 2005 a. 194; 2005 a. 443 s. 265; 2007 a. 20, 36; 2009 a. 14, 28.

SECTION 4. 120.13 (2) (g) of the statutes, as affected by 2009 Wisconsin Act 28, is amended to read:

120.13 **(2)** (g) Every self-insured plan under par. (b) shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.87 (4), (5), and (6), 632.885, 632.895 (9) to (17), 632.896, and 767.513 (4).

NOTE: NOTE: Par. (g) is shown as amended eff. 1-1-10 by 2009 Wis. Acts 14 and 28. Prior to 1-1-10 it reads as follows. The correct cross-references are shown in brackets.NOTE:

(g) Every self-insured plan under par. (b) shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.85, 632.853, 632.855, 632.87 (4) and (5) [s. 632.87 (4), (5), and (6)], 632.895 (9) to (15), 632.896, and 767.25 (4m) (d) [s. 767.513 (4)].

History: 1973 c. 94, 290; 1975 c. 115, 321; 1977 c. 206, 211, 418, 429; 1979 c. 20, 202, 221, 301, 355; 1981 c. 96, 314, 335; 1983 a. 27, 193, 207, 339, 370, 518, 538; 1985 a. 29 ss. 1725e to 1726m, 1731; 1985 a. 101, 135, 211; 1985 a. 218 ss. 12, 13, 22; 1985 a. 332; 1987 a. 88, 187; 1989 a. 31, 201, 336, 359; 1991 a. 39, 226, 269; 1993 a. 16, 27, 284, 334, 399, 450, 481, 491; 1995 a. 27 ss. 4024, 9126 (19), 9145 (1); 1995 a. 29, 32, 33, 65, 75, 225, 235, 289, 439; 1997 a. 27, 155, 164, 191, 237, 335; 1999 a. 9, 19, 73, 83, 115, 128; 1999 a. 150 s. 672; 1999 a. 186; 2001 a. 38, 98, 103, 105; 2003 a. 254; 2005 a. 22, 194, 290, 346; 2005 a. 443 s. 265; 2007 a. 20 ss. 2738, 9121 (6) (a); 2007 a. 36, 70, 97; 2009 a. 14, 28.

(END OF INSERT 3-17)

INSERT 8-21 1 of 2

SECTION 5. 185.981 (4t) of the statutes, as affected by 2009 Wisconsin Act 28, is amended to read:

185.981 **(4t)** A sickness care plan operated by a cooperative association is subject to ss. 252.14, 631.17, 631.89, 631.95, 632.72 (2), 632.745 to 632.749, 632.798, 632.85, 632.853, 632.855, 632.87 (2m), (3), (4), (5), and (6), 632.885, 632.895 (10) to (17), and 632.897 (10) and chs. 149 and 155.

NOTE: NOTE: Sub. (4t) is shown as amended eff. 1-1-10 by 2009 Wis. Acts 14 and 28. Prior to 1-1-10 it reads as follows. The correct cross-references are shown in brackets.NOTE:

(4t) A sickness care plan operated by a cooperative association is subject to ss. 252.14, 631.17, 631.89, 631.95, 632.72 (2), 632.745 to 632.749, 632.85, 632.853, 632.855, 632.87 (2m), (3), (4), and (5) [s. 632.87 (2m), (3), (4), (5), and (6)], 632.895 (10) to (15), and 632.897 (10) and chs. 149 and 155.

History: 1971 c. 40 s. 93; 1971 c. 307 s. 118; 1975 c. 98; 1975 c. 223 s. 28; 1975 c. 224 s. 146; 1975 c. 421; 1981 c. 39 s. 22; 1981 c. 205; 1981 c. 391 s. 210; 1985 a. 29; 1985 a. 30 s. 42; 1987 a. 27 ss. 1917e, 3202 (47) (a); 1987 a. 312 s. 17; 1989 a. 121, 129, 200, 201, 336; 1991 a. 39, 123, 269; 1993 a. 27, 450, 481; 1995 a. 27, 118, 289; 1997 a. 27, 155, 237; 1999 a. 95, 115; 2003 a. 321; 2005 a. 194; 2007 a. 36; 2009 a. 14, 28.

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SECTION 6. 185.983 (1) (intro.) of the statutes, as affected by 2009 Wisconsin Act 28, is amended to read:

185.983 **(1)** (intro.) Every such voluntary nonprofit sickness care plan shall be exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44, 601.45, 611.67, 619.04, 628.34 (10), 631.17, 631.89, 631.93, 631.95, 632.72 (2), 632.745 to 632.749, 632.775, 632.79, 632.795, 632.798, 632.85, 632.853, 632.855, 632.87 (2m), (3), (4), (5), and (6), 632.885, 632.895 (5) and (9) to (17), 632.896, and 632.897 (10) and chs. 609, 630, 635, 645, and 646, but the sponsoring association shall:

NOTE: NOTE: Sub. (1) (intro.) is shown as amended eff. 1-1-10 by 2009 Wis. Acts 14 and 28. Prior to 1-1-10 it reads as follows. The correct cross-references are shown in brackets.NOTE:

(1) Every such ~~voluntary nonprofit sickness care plan shall be exempt~~ from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44, 601.45, 611.67, 619.04, 628.34 (10), 631.17, 631.89, 631.93, 631.95, 632.72 (2), 632.745 to 632.749, 632.775, 632.79, 632.795, 632.85, 632.853, 632.855, 632.87 (2m), (3), (4), and (5) [s. 632.87 (2m), (3), (4), (5), and (6)], 632.895 (5) and (9) to (15), 632.896, and 632.897 (10) and chs. 609, 630, 635, 645, and 646, but the sponsoring association shall:

History: 1975 c. 98; 1975 c. 224 s. 146; 1975 c. 352; 1975 c. 422 s. 163; 1977 c. 339; 1979 c. 89; 1981 c. 20; 1981 c. 39 s. 22; 1981 c. 82; 1981 c. 391 s. 210; 1983 a. 189 s. 329 (25); 1983 a. 396; 1985 a. 29 ss. 2060d to 2060r, 3202 (30); 1987 a. 27, 325; 1989 a. 23, 31, 129, 200, 201, 336, 359; 1991 a. 39, 189, 250, 269, 315; 1993 a. 450, 481, 482; 1995 a. 289; 1997 a. 27, 155, 237; 1999 a. 95, 115; 2003 a. 321; 2005 a. 194; 2007 a. 36; 2009 a. 14, 28.

(END OF INSERT 8-21)

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-3042/1dn
RLR:/:...
GS

late

Senator Sullivan: ΔS·Δ

In addition to the changes you requested, this redraft makes changes to proposed Δ146.903 (5). Rather than requiring health care providers to post notice that a consumer has a right to "request" charge information, the redraft states that a consumer has a right to "receive" the information. Please let me know if you prefer the original language.

Robin Ryan
Legislative Attorney
Phone: (608) 261-6927
E-mail: robin.ryan@legis.wisconsin.gov

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-3042/1dn
RLR:cjs:jf

November 3, 2009

Senator Sullivan:

In addition to the changes you requested, this redraft makes changes to proposed s. 146.903 (5). Rather than requiring health care providers to post notice that a consumer has a right to "request" charge information, the redraft states that a consumer has a right to "receive" the information. Please let me know if you prefer the original language.

Robin Ryan
Legislative Attorney
Phone: (608) 261-6927
E-mail: robin.ryan@legis.wisconsin.gov

Parisi, Lori

From: Cornell, Mary
Sent: Tuesday, December 01, 2009 11:47 AM
To: LRB.Legal
Subject: Bill Jacket for LRB 3042/1

Hi,
Can we have a bill jacket for LRB 3042/1, relating to disclosure of information by health care providers and insurers, delivered to our office?

Thanks!

Mary Cornell
Office of State Senator Jim Sullivan
State Capitol, Rm 15 South
P.O. Box 7882
Madison, WI 53707-7882
(608) 266-2512